month later the patient was discharged in a good general state, but with multiple fistulæ at the site of the operation. When shown to the Society 1½ years after the operation, she was feeling and looking quite well, her lungs being apparently entirely sound. The fistules, however, still remained; there was also present slight swelling about the sternum and the rib operated upon.—*Vratch*, No. 42, 1890, p. 967.

VALERIUS IDELSON (Berne).

II. Recovery From Acute Diffuse Suppurative Peritonitis by Laparotomy. By Mr. HAWKINS-AMBLER and Mr. LAWFORD KNAGGS. The authors report to the Clinical Society of London a case of suppurative peritonitis, occurring in a boy, æt. 9, and giving all the symptoms of intestinal obstruction. The obstruction was due to adhesions which so held the gut in Douglas' pouch as to kink it. Operation was done on the second day after the development of the symptoms. The adhesions were broken down by the fingers, the pus evacuated and drainage tubes inserted, the peritoneum not being washed. The authors lay stress on this point, as they believe any attempt at washing would have produced a fatal result.—*Brit. Med. Jour.*, May 15, 1890.

III. A Case of Fæcal Extravasation into the Peritoneal Cavity; Thorough Washing of the Peritoneum; Recovery. By HARRISON CRIPPS, F.R.C.S. (London). Mr. Cripps reports a case of carcinoma of the rectum, in a woman, æt. 52, for which he did an inguinal colotomy, opening the bowel on the second day after the operation. On the fifth day, during a fit of coughing, the sutures gave way and the bowel fell back, allowing fæces to flow into the abdominal cavity. This was soon followed by much pain and the symptoms of collapse. Five hours later the wound was opened, the bowel raised into the wound, the entire peritoneal cavity flushed until the returning water came away clean, and a glass drainage-tube was then introduced. No anæsthetic was used. The pain entirely ceased immediately after the washing. She did not recover entirely from the shock for nearly 3 days. After that time she went on to a complete recovery. Cripps calls attention to the severe pain produced

by the presence of fæces in the peritoneal cavity, the immediate cessation of it on cleansing the parts, and the non development of second-day peritonitis.—*Brit. Med. Jour.*, March 1, 1890.

H. BEECKMAN DELATOUR (Brooklyn).

IV. Case of Enormous Acute Abscess of the Abdominal Wall; Recovery. By Dr. LEONTY P. ALEXANDROFF (Moscow, Russia). The writer records the following exceedingly rare case: A previously generally healthy little girl of 3 years and 7 months, of a healthy family, had had a sharp attack of acute colitis. About a month after a complete recovery from the disease there appeared a gradually increasing enlargement of the abdomen, accompanied by high fever, semi-conscious state (of 4 days' duration), and vomiting. On the eleventh day of the affection, the navel (which became very prominent) burst, and an enormous quantity of pus escaped. When admitted to St. Olga's Hospital for Children, on the twenty-first day (of the disease), the child was extremely emaciated and exhausted. In the umbilical region there was situated a fistula, encircled with flabby fungating granulations, and profusely discharging a thin, greenish pus. The recti abdominis were sharply delineated, while the abdomen was neither distended, nor markedly tender on palpation. The child's stools remained regular all through. On examination (under chloroform), by means of a thick and long silver probe, there was discovered a cavity, lying between the anterior abdominal wall and parietal layer of the peritoneum, and occupying the whole region from the diaphragm down to the navel on the median line, and to a point in two fingers' breadth above the anterior superior iliac spine on either side. The abscess, seemingly, extended far backward beneath the diaphragm, and encroached the axillary lines in lateral direction. The treatment consisted in opening the abscess with two vertical incisions, each 4 cm. long, at the level of the navel and slightly below the costal arches. The cavity was thoroughly washed out with a boracic acid solution and supplied with drainage-tubes, the remaining portions of the wounds being closed with silk. The after-course was most satisfactory. Fever rapidly subsided, the discharge quickly decreased, the